Child Abuse Review Vol. **13**: 338–352 (2004)
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/car.862

Daniel T. Wilcox*
Wilcox Psychological Associates
University of Birmingham
Birmingham, UK

Fiona Richards
NSPCC
Children's Services
Staffordshire, UK

Zerine C. O'Keeffe
Wilcox Psychological Associates
University of Birmingham
Birmingham, UK

Resilience and Risk Factors Associated with Experiencing Childhood Sexual Abuse

The effects of child sexual abuse are wide-ranging and impact on children, families and health/social care systems. The authors review this literature, examining the shortcomings of the 'victim–offender' model, and consider the complex, multifactorial nature of this question. Factors associated with a progression from victim to perpetrator are explored and the prevalence of abuse in the general population is also discussed. Protective as well as risk factors are considered and the pivotal role of 'personal reliance' is considered as it relates to empowering damaged young people to become healthy adults. The authors also discuss implications for the treatment of young people who become abusers. Two case examples are briefly reported upon and the article concludes with a consideration of ways to helpfully address the needs of children who become sexual perpetrators.

KEY WORDS: child sexual abuse; resilience; risk; survivor

For years, professionals have been endeavouring to understand and address the wide-ranging effects of child sexual abuse. For example, work by Beitchman *et al.* (1991) and Corby (2001) suggests that sexual abuse is most damaging when it involves a betrayal of trust and the child is not listened to or believed in respect of the abuse. Researchers have also considered the broad public health impact in the general population and its effects on primary care and specialist health/social care services. At present, there is a mass of government guidance emphasizing the need for agencies to work effectively together. For example, the Department of Health, Home Office, Department for Education and Employment (1999) highlights the importance of interagency working to safeguard

'A mass of government guidance emphasizing the need for agencies to work effectively together'

* Correspondence to: Dr D. T. Wilcox, Wilcox Psychological Associates, 9/10 Frederick Road, Edgbaston, Birmingham B15 1JD, UK. Tel: 0121 454 8222. Fax: 0121 454 2999. E-mail: daniel-wilcox@btconnect.com

 Accepted 12 July 2004

and promote the welfare of children. This document emphasizes the potential long-term effects of abuse, noting the difficulties that may extend into adulthood. It calls for all health and social care services to share responsibility and collaborate in response to children who have suffered or are likely to suffer significant harm.

Researchers and practitioners have also been attempting to understand how sexually abusive experiences influence known sexual abuse survivors. Lev-Wiesel (2000) suggests victims were able to survive with positive indicators of self-esteem if they placed the responsibility for the abuse with the abuser and not themselves. In particular, researchers have attempted to determine what, if any, relationship exists between the experience of child abuse (including neglect) and the future development of patterns of offending behaviour. Cunningham and Macfarlane (1991) explored the notion that children who display sexually harmful behaviour are themselves victims of sexual abuse. The phrase 'abuse reactive' children was used in the development of a treatment programme for preadolescent children (Garland and Dougher, 1990). They advised that the term 'abuse reactive' is not intended to categorically make a direct causal link, rather that a history of abuse is a relevant factor in the development of problematic sexual behaviour in children. Garland and Dougher (1990) concluded that the abused/abuser hypothesis is simplistic and misleading. The notion of a link is complex and open to further debate.

'To understand how sexually abusive experiences influence known sexual abuse survivors'

In the UK, the NSPCC and other specialist services providers are regularly placed at the interface between child protection services and the criminal justice system. These services frequently advocate for the child in need, recognizing the dilemmas and uncertainty associated with unidimensional notions about causation and potential risk. Increasingly, specialist services are being designed to work with young people referred because of histories of childhood abuse and neglect. One ongoing interest has been the consideration of whether there is evidence of a victim–offender cycle predicting that young victims of abuse will be at significant risk of going on to abuse others.

'The dilemmas and uncertainty associated with unidimensional notions about causation and potential risk'

The 'Victim–Offender' Question

In 1988, Johnson reported that of 47 preadolescent males (under age 13) in treatment for sexual aggression, nearly half (49%) had been sexually abused themselves. A year later, focusing on offending girls, Johnson (1989) found that all of

the 13 sexually aggressive females (under age 12) undergoing treatment had themselves experienced serious sexual abuse. More recently, Burton *et al.* (1997) completed a much larger study and found that among 287 sexually aggressive pre-teenage males and females, 206 (72%) had been victims of sexual abuse. Matthews *et al.* (1997) estimated that three out of four girls and women who sexually abuse have themselves been subject to such harm.

Ryan *et al.* (1996) have reported a lower rate of sexual victimization for male adolescents who sexually offend (approximately 40%), positing that other factors/motivations must be considered for this group. Erooga and Masson (1999) note a greater diversity in patterns of offending and target groups in pubescent boys wherein sexual assaults on adults become more prevalent. Barbaree *et al.* (1993) reported that individuals who perpetrate sexual abuse on adults are less likely to have been sexually abused as children than those who sexually abuse children. However, they reported considerable evidence of other forms of abuse (emotional and physical) and neglect in the histories of both groups. Notably, they identified wide-ranging domestic violence experiences among individuals who sexually assault adults. Additionally, Widom and Ames (1994) and Widom (1995) reported that childhood victims of physical abuse were more likely than victims of neglect to be arrested for acts of rape or sodomy.

'Identified wide-ranging domestic violence experiences among individuals who sexually assault adults'

Wilcox and Richards (2002) reported their practice-based indications lending support to these various multifactored findings. However, they stressed the importance of considering that referrals had come predominantly from Social Services and the Youth Offending Service. This might mean that these already vulnerable children were having their behaviour even more closely scrutinized than would obtain in the general population.

Dobash *et al.* (1993) found that among the 213 sexual abuse case files they reviewed, only 17% indicated incidents of prior sexual victimization, positing that 'cause and effect' attitudes about the onset of sexual offending might be premature judgements to make at this time. However, they recognized that these offender records might not have explored personal experiences of sexual harm. Research by Craissati *et al.* (1999) identified that among their adult subjects who had abused children, only 50% reported being victimized themselves.

Importantly, the Association for the Treatment of Sexual Abusers (1997, p.1) reported, 'there is little evidence to support the assumption that the majority of juvenile sexual offenders are destined to become adult sexual offenders, or that these youths engage in sexual (offending) for the same

reasons as their adult counterparts'. Supporting this view, Kaufman and Zigler (1987) found that only 30% of parents who had suffered abuse during their childhood (emotional, physical or sexual) perpetrated abuse against their own children. Abel (1999) expressed concerns about making causal links between experiencing abuse and perpetrating abuse against others, based on non-representative populations. He cautioned that one must be particularly attentive to whether research is retrospective or prospective in nature. For example, he observed that a prospective study among the population of individuals who smoke cigarettes would only reveal a small proportion of people dying of lung cancer. However, among a population of patients on a ward for the treatment of lung cancer (a retrospective study), the vast majority of patients would be former smokers. In much the same way, Abel concluded that the majority of child abusers have been sexually abused, yet most people who are sexually abused do not go on to offend.

'Concerns about making causal links between experiencing abuse and perpetrating abuse against others'

Further Considerations

Skuse *et al.* (1997) identified factors lending support to Widom (1995) that increased the probability of sexually abusive behaviour occurring in the absence of childhood sexual victimization. Research by Han (1999) explored the effects of emotional distress and ensuing trauma following child abuse. The researchers showed indications that society's reaction to abuse, rather than exposure *per se*, substantially determined whether sexually abused individuals would repeat these abusive experiences.

'Sexually abusive behaviour occurring in the absence of childhood sexual victimization'

Finkelhor and Browne (1986) used their traumagenic model to try to explain why some children go on to offend against others. They argued that such behaviour arises as a response to their own early negative experiences. Part of the model suggests that the sense of 'powerlessness' as a factor in the abuse experience may cause the child to try to dominate others. The reenactment of what happened to them may provide some relief from the lack of control they experienced during their victimization. Findings by Veneziano *et al.* (2000) supported the Finkelhor and Browne model. They concluded that not only had 92% of their 74 adolescent male sex offenders been sexually abused, but that their chosen victims and sexual behaviours were reflective of their own victimization.

Considering this from a different perspective, the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) details the diagnostic criteria

for post-traumatic stress disorder, noting the psychological effects of being confronted with seriously injurious or threatening circumstances. The condition is often characterized by reexperiencing these events, in addition to other clinical features. Among children, unresolved trauma can give rise to disturbing symptoms, including feelings of helplessness as well as disorganised or agitated behaviour. In young children, repetitive play may occur in which aspects of the unresolved trauma are expressed. In the aftermath of a serious road traffic accident, a child might reenact the incident so repeatedly that the toy vehicles become damaged. The activity serves to address and resolve/dispel the feeling of confusion and distress that the victim of these events continues to experience. In much the same way, sexual trauma can be revisited by child victims who are seeking to resolve and clarify these complicated and disturbing issues.

'Sexual trauma can be revisited by child victims who are seeking to resolve and clarify these complicated and disturbing issues'

In the absence of therapeutic guidance and support from others, there is a greater likelihood that the individual will 'revisit' the sexual trauma in a maladaptive or unhelpful way, which may lead to further harmful effects on other innocent young people. Watkins and Bentovim (1992) reported that in their research, one in five sexually abused boys goes on to sexually offend against others by the time they are teenagers. As regards the treatment of trauma, Briere (1996) gives a comprehensive model of symptom development and subsequent therapeutic focus in his 'self-trauma model' for treating adult survivors of severe child abuse. He notes that the model applies to early intervention as well, advising of the great importance of taking speedy remedial steps to avoid significant psychological harm. Hunter (1997) reported that failure to address PTSD in young people increases the probability of serious conduct disordered behaviour which may become wide-ranging. This, in turn, may give rise to marked characterological disturbances in adult life, including antisocial personality disorder (American Psychiatric Association, 2000).

Prevalence of Abuse

Research findings have suggested that between two and four females out of 10 have been sexually abused, while approximately half as many males have been sexually abused (Cawson *et al.*, 2000). (It should be borne in mind, however, that prevalence rates vary depending on how abuse is defined.) The literature also indicates that non-contact offences are reported less often, as well as incest offences. Indeed, the majority of victims never report being abused, as noted by Pilkington and

Kremer (1995). Metropolitan Police and Bexley Social Services (1987) data suggest that of those child sexual abuse cases referred, among very young children (under age 5), boys are at least as likely to be sexually abused as girls, although as they become older, girls are increasingly more likely to be targeted.

General population estimates would suggest that one in 100 children are sexually abused by a father or father figure (Laurance, 2000). It is of considerable interest that estimates further suggested that two in 100 children are sexually abused by siblings. In respect of issues concerning the traumatic effects of sexual abuse, it seems significant that, despite these statistics, fathers are twice as likely as siblings to be reported as abusers within mental health or counselling settings. One interpretation of these findings might be that the emotional injury caused by parent abuse, e.g. increased feelings of powerlessness and betrayal as described in Finkelhor and Browne's (1986) 'traumagenic model', produces greater psychological harm.

'Estimates further suggested that two in 100 children are sexually abused by siblings'

Intervening Protective Variables

Many professionals are heartened by the resilience of young people: both those who experience childhood abuse but do not go on to offend and those who cease this behaviour when they enter into adult life (Wilcox and Richards, 2002). They impress upon practitioners the need to understand features that are present for these young people that could be identified as protective factors. It is commonly acknowledged that the nature and extent of the sexual abuse experienced, the victim's relation to the perpetrator and their perception of the abuse can affect not only how victims view themselves but also their capacity to cope over time (Salter, 1988, 1995).

Lev-Wiesel (2000) determined that adult survivors were more likely to report a better quality of life and higher self-esteem if they attributed the onset of sexual abuse to characteristics of their abuser, as opposed to blaming themselves or situational factors. Briggs and Hawkins (1996) found that those men who had normalized their own experience of sexual abuse were more likely to offend against others. Elliot, as reported by Hunter (1997), reported that adolescent sexual offenders were less likely to continue offending in adult life if they acquired a capacity to engage successfully in adult relationships and maintain employment. Gilgun (1990) identified a related critical factor affecting whether a child victim of sexual abuse went on to victimize other children in adulthood. This study concluded that those who did not molest children

'Those who did not molest children were more likely to have experienced a close relationship with someone in whom they could confide'

were more likely to have experienced a close relationship with someone in whom they could confide.

Corby (2001) concluded that, while both the sex and age of the child can affect how the abuse experience manifests itself later on, research so far does not give enough indication of the direction of these variable effects. Nonetheless, he tentatively determined that sexual abuse is likely to be most damaging when: penetration is involved; abuse continues over a longer period of time; the abuser is a father figure; the abuse coincides with the threat of violence or actual harm; and the victim is not believed or supported by significant others. This conclusion concurs with reviews conducted by Kendall-Tacktt *et al.* (1993) and Beitchman *et al.* (1991).

The research of Briggs and Hawkins (1996) advised against drawing any sweeping conclusions based on individual or isolated 'risk' factors. Additionally, they asserted that the nature of the abuse (i.e. touching or sexual penetration) inflicted upon a child has no bearing on whether the victim goes on to abuse others. This note of caution is further supported by Lambie *et al.* (2002), who found no significant difference between their 'resilient non-offenders' (those abused as children who have not subsequently been convicted of sexual offences) and the 'victim–offender' group (those who went on to commit sexual offences) with regard to frequency and length of abuse suffered as a child or closeness/relationship with their perpetrator. Indeed, Lambie *et al.* (2002) echoed observations made by a variety of researchers and practitioners (West, 1985), postulating that it is the perception of the abuse held by the child which will often determine the degree to which they are adversely affected by the abuse.

'It is the perception of the abuse held by the child which will often determine the degree to which they are adversely affected by the abuse'

Personal Resilience

Wilcox and Richards (2002) considered the construct of personal resilience, the pivotal role it can play and how it could be effectively used in the development of intervention programmes practitioners are currently delivering. They advise that resiliency refers to an individual's capacity for successfully adapting to adverse and traumatic life events. They describe trauma as the experience of feeling frightened, objectified and helpless in the face of human aggression or situational calamities. Importantly, they assert that these circumstances are mediated by the individual's own physical or psychological limitations.

'Resiliency refers to an individual's capacity for successfully adapting to adverse and traumatic life events'

Salter (1995) advised that trauma appears not only to change the way people feel, it changes the way they think as

well. Spiegal (1990, p.252), reporting on the psychological damage caused by abuse, noted that, 'along with the pain and fear comes a marginally bearable sense of helplessness, a realisation that one's own will and wishes become irrelevant to the course of events, leaving a damaged or fragmented sense of self'.

'Leaving a damaged or fragmented sense of self'

In considering those protective characteristics that assist in developing personal resilience, Garmezy (1985) identified as factors: (a) personality traits like self-esteem and social skills; (b) family characteristics, including support and a harmonious environment; and (c) external supports which enhance a child's ability to cope. Conte and Schuerman (1987) found that a supportive response from the victim's family following disclosure of sexual abuse contributed towards moderating the effects of the abuse and reducing adjustment problems. More recently, Lambie *et al.* (2002) reported that men in their 'resilient non-offenders' sample received emotional support from a wider variety of sources than their 'victim–offender' counterparts. Furthermore, those who subsequently offended against others were more likely to have experienced an adverse home life which hindered them from receiving support. Briggs and Hawkins (1996) reported that the backgrounds of perpetrators they studied who had been sexually abused during childhood were more likely to be characterized by greater degrees of physical and verbal abuse (and less warmth/affection) than those individuals who were victimized but had not later committed offences.

Lambie *et al.* (2002) also found that their 'non-offending' group who had been sexually abused during childhood had a higher level of education than those in the 'victim–offender' group. This positive risk factor had been previously suggested by Herrenkhol *et al.* (1994) and Werner (1989). Further, Herrenkhol *et al.* (1994) believed that normal intellectual functioning can be an important determinant of whether adolescents will develop a resilient response to abuse that they experience. They reasoned that good school performance, coupled with wide-ranging peer affiliations, enhances the victim's positive perceptions about himself, facilitating the potential for overcoming the damaging effects of abuse.

'Good school performance, coupled with wide-ranging peer affiliations, enhances the victim's positive perceptions about himself'

Norring and Walker (2001) identified ways that therapeutic work can be structured to stimulate this effect. They highlighted the importance of external support groups to help overcome the trauma of abuse. They found that a peer group approach employed with 15–20-year-old female survivors of sexual abuse helped to reduce psychosocial difficulties and even general health problems. In addition, this approach contributed to the prevention of future victimization and social

isolation. Johnson (1989) investigated these factors in sexually abusive girls, noting that these girls had no friends of their own age. Research by Ryan and Lane (1991) also found this trend in adolescent male sexual abusers, positing that early intervention to develop relationships and related skills might play an important role in mitigating future offending risk.

Although these factors are not sufficiently understood to enable practitioners to fully discern their complex interrelationships, considerable guidance is offered towards the development of more informed treatment work with young people.

Implications

Current practice research (Wilcox and Richards, 2002) indicates that effective services for young people who display inappropriate sexual behaviour need to work towards processing trauma and strengthening personal resilience. The role of family and friends in supporting and enabling this process is crucial and linked to the building of positive self-esteem. In attempting to promote these interventions, practitioners are working towards creating adaptive coping strategies to assist young people in changing inappropriate behaviours.

'Creating adaptive coping strategies to assist young people in changing inappropriate behaviours'

Mullholland and McIntee (1999) suggest that it is possible to develop a model to accommodate trauma as an integral part of intervention while not losing sight of the child's inappropriate sexual behaviour and concomitant risk. Wilcox and Richards (2002) assert that effective interventions for inappropriate sexual behaviour require early, holistic and well-targeted strategies involving young people and their families. They emphasize empowerment and the avoidance of labelling.

Case Examples

Wilcox and Richards (2002) presented the following two case examples for a NOTA training event, 'Sex offenders and the community', to illustrate key issues about treatment and rehabilitation planning.

William

William was a 16-year-old boy with moderate learning difficulties. He attended a residential special school and went home at weekends. There was a history of sexual abuse in his family. William's father was convicted and imprisoned for sexually

abusing William's older brother. It was unclear whether any of the other children, including William, were abused.

The first concerns about William's behaviour were noted at school and described as sexual experimentation. The details of this were not reported. William's mother developed a new relationship and had two more children. William began to struggle with his sibling relationships and there was a high level of conflict. The family described challenging behaviours when William visited at weekends.

William was reported for a sexual assault against a female peer at school. William's younger brother also disclosed that William had been touching him in a sexual way. This provoked a family crisis and reawakened past traumatic events. There was a family belief that William had inherited his father's abusive behaviour.

'Provoked a family crisis and reawakened past traumatic events'

There was a child protection conference that resulted in the children's names being placed on the child protection register and William was accommodated. A specialist assessment was undertaken and began by looking at the family history. The assigned NSPCC assessor reported feeling overwhelmed by the nature of this family's abusive experiences, questioning in turn how the family must feel.

William continued to display inappropriate sexual behaviour while in residential care and his first placement broke down. Following a move to another unit, William alleged that another resident sexually and physically abused him. This was reported to the police. William also displayed further inappropriate sexual behaviour. A decision was taken to return William home. There was a high level of anxiety, but a structured programme of family support and intensive work with William and his parents together gradually enabled the family to recover and feel more in control.

'Family support and intensive work with William and his parents together gradually enabled the family to recover'

William continued to display challenging behaviours, but his parents grew in their confidence to manage this. There was no legal action against William due to a lack of evidence and his level of disability.

A plan was pursued to continue working towards building the parents' confidence, encouraging emotional warmth and a nurturing environment for all the family. Importantly, a broad therapeutic aim was to promote the whole family's development of resilience.

In retrospect, there was professional consensus that the involvement of parents and carers was essential to providing the encouragement and support this young person required. Particular emphasis was placed on establishing a working relationship that modelled the behaviours that staff were striving to engender.

In contrast to this experience, a further case example is described.

Barry's Story

Barry was a 16-year-old boy with no recognized learning difficulty, although he was described as below average in his academic achievement. There was a history of sexual abuse and domestic violence throughout Barry's childhood. It was not clear whether Barry was abused, but he had witnessed violence including serious sexual harm. Barry's cousin and younger sister disclosed that Barry had been sexually abusing them and an investigation uncovered clear supportive evidence.

'It was not clear whether Barry was abused, but he had witnessed violence'

Barry was charged with three counts of indecent assault and one of attempted rape. He was advised to plead not guilty and gave a no-comment interview. A court process ensued and the attempted rape charge was dropped. Specialist services could not work with Barry because of the legal proceedings. Barry was found guilty of the indecent assault 18 months later. He was made subject to a 3-year supervision order and registered on the sex offender register for $2^1/_2$ years. He was referred to a group work programme, where he was allowed to avoid any discussion of his offences against his family.

Barry struggled to engage with the work so long after the event, but marginally fulfilled the conditions of the order. Continued attempts were made to engage Barry and his family in work focused on developing adaptive strategies, but there was little evidence of motivation or commitment to engage. Both the impact of the protracted legal process and the consequences for Barry in terms of curtailed employment and training opportunities (because of his SO registration) served to create a barrier to therapeutic engagement that was difficult to overcome.

'A barrier to therapeutic engagement that was difficult to overcome'

The intervention strategies operate alongside the wider societal views concerning youth crime and sex offending. Although the sex offender legislation and register applies to young people, it is based on models that are used with adults. Professionals are particularly concerned about the consequent labelling of young offenders and the punitive disempowering elements that can come into play and from which young perpetrators require protection and guidance. Unfortunately, the traumatized child is often lost. Treatment providers are not encouraged to provide excuses or minimize the harm the offending behaviour has caused, but without professional support/control this process has provided a negative effect on the development of positive relationships and equal life opportunities. Further, these events can create further potentially

'The traumatized child is often lost'

traumatic experiences for the vulnerable and excluded young person and his family.

In Barry's case, development of personal resilience was considerably more challenging owing in large part to extraneous societally determined factors. However, Barry was beginning to make progress. Fortunately, the framework of the supervision order enabled professional workers to remain involved over an extended period of time and, through these efforts, Barry became well engaged in the work.

Summary

To date, there is little evidence to support the notion that young people who display sexually harmful behaviours are likely to become adult sex offenders or engage in the behaviour for the same reasons as adults. In the light of this and emerging work about the importance of personal resilience as a protective factor, the authors advise of an increasing need for flexibility, benevolence and understanding in offering treatment to young people.

'An increasing need for flexibility, benevolence and understanding in offering treatment to young people'

Chaffin and Bonner (1998) noted that a significant proportion of sexual offending is committed by children and teenagers. They also noted that some of these youngsters continue abusing in adulthood. As such, they highlighted the enormous importance of identifying those truly at risk, in order that local work can be carried out with them so our communities will be safer. However, they also cautioned, 'we should not forget that these are children and we should think carefully about their rights and welfare' (Chaffin and Bonner, 1998, p.315).

As we have a mandate to adapt treatment to the needs of each young person, adhering to a clear value set utilizing informed research and establishing relevant therapeutic aims, this shared responsibility is key to the process of enabling and empowering damaged young people to become healthy adults.

References

Abel GG. 1999. Assessing and treating sex offenders. Paper presented at the Specialised Services Conference Presentation on Assessing & Treating Sex Offenders, Chicago, IL, August 1999.

American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Text Revision.* APA: Washington, DC.

Association for the Treatment of Sexual Abusers. 1997. *Position on the Effective Legal Management of Juvenile Sexual Offenders*. ATSA: Beaverton, Oregon.

Barbaree HE, Marshall WL, Hudson SM (Eds). 1993. *The Juvenile Sex Offender*. Guilford Press: New York.

Beitchman JH, Zucker KJ, Hood JE, Da Costa GA, Ackman D. 1991. A review of the short-term effects of child sexual abuse. *Child Abuse and Neglect* **15**: 537–556.

Briere J. 1996. A self-trauma model for treating adult survivors of severe child abuse. In *The APSAC Handbook on Child Maltreatment*, Briere J, Berliner L, Bulkley JA, Jenny C, Reid T (Eds). Sage: Thousand Oaks, CA; 140–157.

Briggs F, Hawkins RMF. 1996. A comparison of the childhood experiences of convicted male child molesters and men who were sexually abused in childhood and claimed to be non-offenders. *Child Abuse and Neglect* **20**: 221–233.

Burton DL, Nesmith AA, Badten L. 1997 Clinician's views on sexually aggressive children and their families: a theoretical explanation. *Child Abuse and Neglect* **21**: 157–170.

Cawson P, Wattam C, Brooker S, Kelly G. 2000. *Child Maltreatment in the United Kingdom: A Study of the Prevalence of Child Abuse and Neglect*. NSPCC: London.

Chaffin M, Bonner BL. 1998. Don't shoot: we're your children. *Child Maltreatment* **3**: 314–416.

Conte JR, Schuerman JR. 1987. Factors associated with an increased impact of child sexual abuse. *Child Abuse and Neglect* **11**: 201–211.

Corby B. 2001. *Child Abuse: Towards A Knowledge Base*, 2nd edn. Open University Press: Buckingham.

Craissati J, McClurg G, Falla S. 1999. The challenge project. *Child Sexual Abusers in South East London: Profile, Treatment and Outcome*. Internal Document, Oxleas NHS Trust.

Cunningham C, Macfarlane K. 1991. *When Children Molest Other Children*. Safer Society.

Department of Health, Home Office, Department for Education and Employment. 1999. *Working Together to Safeguard Children*. The Stationery Office: London.

Dobash RP, Carnie J, Waterhouse L. 1993. Child sexual abusers: recognition and response. In *Child Abuse and Abusers: Protection and Prevention*, Waterhouse L (Ed.). Jessica Kingsley: London.

Erooga M, Masson H. 1999. *Children and Young People who Sexually Abuse Others: Challenges and Responses*. Routledge: London.

Finkelhor D, Browne A. 1986. Initial and long-term effects: a conceptual framework. In *Sourcebook on Child Sexual Abuse*, Finkelhor DA. Sage: Beverley Hills.

Garland RJ, Dougher MJ. 1990. The abused/abuser hypothesis of child sexual abuse: a critical review of theory and research. In *Pedophilia: Biosocial Dimensions*, Feierman J (Ed.). Springer-Verlag: New York; 488–509.

Garmezy N. 1985. Stress-resistant children: the search for protective factors. In *Recent Research in Developmental Psychopathology*, Stevenson JE (Ed.). Pergamon: Oxford; 213–223.

Gilgun JF. 1990. Resilience and the intergenerational transmission of child sexual abuse. In *Family Sexual Abuse: Frontline Research and Evaluation*, Patten MQ (Ed.). Sage: Newbury Park, CA; 93–105.

Han MK. 1999. The relationship between the severity of early sexual abuse, physical abuse, and the severity of committed sexual offences in a clinical sample of male adult sex offenders (CSAbus). *Dissertation Abstracts International: Section B: The Sciences and Engineering*, **60** (5-B): 2341.

Herrenkhol EC, Herrenkhol RC, Egolf B. 1994. Resilient early school-age children from maltreating homes: outcomes in late adolescence. *American Journal of Orthopsychiatry* **64**: 301–309.
Hunter J. 1997. Juvenile sexual offenders. Conference presentation, Sex offenders—assessment, risk management and treatment. Specialised Training Services, San Diego, California.
Johnson TC. 1988. Child perpetrators—children who molest other children: preliminary findings. *Child Abuse and Neglect* **12**: 219–222.
Johnson TC. 1989. Female child perpetrators: children who molest other children. *Child Abuse and Neglect* **13**: 571–585.
Kaufman J, Zigler E. 1987. Do abused children become abusive parents? *American Journal of Orthopsychiatry* **57**: 186–192.
Kendall-Tackett KA, Williams LM, Finkelhor D. 1993. Impact of sexual abuse of children: a review and synthesis of recent empirical studies. *Psychological Bulletin* **113**: 164–180.
Lambie I, Seymour F, Lee A, Adams P. 2002. Resiliency in the victim–offender cycle in male sexual abuse. *Sexual Abuse: A Journal of Research and Treatment* **14**: 31–48.
Laurance J. 2000. Revealed: the truth about child sex abuse in Britain's families. Child maltreatment in the United Kingdom. *The Independent on Sunday*, 19 November, 2000.
Lev-Wiesel R. 2000. Quality of life in adult survivors of childhood sexual abuse who have undergone therapy. *Journal of Child Sexual Abuse* **9**: 1–13.
Matthews R, Hunter JA, Vuz J. 1997. Juvenile female sexual offenders—characteristics and treatment issues. *Sexual Abuse: A Journal of Research and Treatment* **9**: 187–199.
Metropolitan Police and Bexley Social Services. 1987. *Child Sexual Abuse: A Joint Investigation.* Metropolitan Police and Bexley Social Services.
Mullholland SJ, McIntee J. 1999. The significance of trauma in problematic sexual behaviour. In *Working With Young People who Sexually Abuse: New Pieces of the Jigsaw.* RHP.
Norring F, Walker RMR. 2001. Support and group therapy for adolescents with a history of sexual abuse. *Medicine & Hygiene* **59** (2364): 2022–2026.
Pilkington D, Kremer D. 1995. A review of the epidemiological research on child sexual abuse. Community and college student samples. *Child Abuse Review* **4**: 302–315.
Ryan G, Lane S. 1991. *Juvenile Sexual Offending: Causes, Consequences and Corrections*. Lexington Books: Lexington.
Ryan G, Miyoshi TJ, Metzner JL, Krugman RD, Fryer GE. 1996. Trend in a national sample of sexually abusive youths. *Journal of the American Academy of Child and Adolescent Psychiatry* **35**: 17–25.
Salter AC. 1988. *Treating Child Sex Offenders and Victims: A Practical Guide*. Sage: Thousand Oaks, CA.
Salter A. 1995. *Transforming Trauma: A Guide to Understanding and Treating Adult Survivors of Child Sexual Abuse.* Sage: Thousand Oaks, CA.
Skuse *et al*. 1997. Cited in 'Children and adolescent victims who become perpetrators', Bentovim A, Williams B. (1998). *Advances in Psychiatric Treatment* **4**: 101–107.
Spiegal D. 1990. Trauma, dissociation, and hypnosis. In *Incest Related Syndromes of Adult Psychopathology*, Kluft RP (Ed.). American Psychiatric Press: Washington, DC; 247–261.

Veneziano C, Veneziano L, LeGrand S. 2000. The relationship between adolescent sex offender behaviours and victim characteristics with prior victimisation. *Journal of Interpersonal Violence* **15**: 363–371.

Watkins B, Bentovim A. 1992. The sexual abuse of male children and adolescents: a review of current research. *Journal of Child Psychology and Psychiatry* **33**: 197–248.

Werner EE. 1989. High risk children in young adulthood: a longitudinal study from birth to 32 year. *American Journal of Orthopsychiatry* **59**: 72–81.

West. 1985. Cited in Renvoize J. (1993). *Innocence Destroyed: A Study of Child Sexual Abuse*. Routledge: London.

Widom CS. 1995. *Victims of Childhood Sexual Abuse: Later Criminal Consequences.* US Dept of Justice, Office of Justice Programs, National Institute of Justice: Washington, DC.

Widom CS, Ames MA. 1994. Criminal consequences of childhood sexual victimisation. *Child Abuse and Neglect* **18**: 303–318.

Wilcox DT, Richards F. 2002. Sex offenders and the community. National Organisation for the Treatment of Abusers (NOTA) West Midlands Conference, Stourbridge.

